

Food Distribution Program

Hoopa Valley Tribal Council

P.O. Box 498 • Hoopa, California 95546

(530) 625-4646 • Fax (530) 625-4717

TO ALL FOOD COMMODITIES APPLICANTS

NOTICE

- A. All households with zero or fluctuating income will be certified for three months at a time.
 - B. All households are required to provide a current utility bill (PG&E, water, or propane) or verification of residence at the time of certification to the program.
 - C. All households are required to have verification of current income at the time of certification to the program.
 - D. Must prove membership of a federally recognized tribe; California roll numbers are not acceptable.
 - E. All households are subject to a home visit prior to and during certification period.
 - F. All changes affecting eligibility must be reported within 10 days.
 - G. Increases to the household will be added in the following month.
 - H. All decreases to the household will be made within 10 days.
 - I. Failure to report changes could result in a household receiving USDA commodities to which it is not entitled and will have a claim filed against the household by the Food Distribution Program.
 - J. Commodities not picked up before the last working day of each month will be FORFEITED for that month.
 - K. Commodities can only be issued for the current month.
 - L. You can participate in the Food Distribution Program or the Food Stamp Program, but not at the same time. You must notify the Food Distribution Program and the Food Stamp Program if you intend to change to one program or the other.
 - M. Receiptants of SSI are not eligible for the Food Distribution Program.
 - N. Households must live in a rural area, not within city limits or in a town with population of over 10,000.
- The FDP has seven (7) working days in which to process an application unless it is an emergency.
- I have read and understand the above requirements for the program.

Participant signature

Date



FOOD DISTRIBUTION PROGRAM

HOOPA VALLEY TRIBAL COUNCIL

P.O. BOX 498

HOOPA, CA 95546

530-625-4646

fax 625-4717

FOR OFFICE USE ONLY:

I.D. NUMBER: _____

D.O.B. _____

Date Received _____

Tribe _____ # _____

Area _____

H.H. _____

County _____

New Application _____

Recertification _____

Warehouse Hours: Monday through Friday 9:00 a.m. to 3:45 p.m.
Office Hours: Monday through Friday 8:00 a.m. to 4:30 p.m.

Answer the following questions honestly and completely. If you know but refuse on purpose to give any needed information, your household (you and the people who live and eat with you) will not be eligible for food distribution.

You may complete this form at home and mail it or bring it to the office. Or, another member of your household, or an adult who knows you may complete and return it to us.

"We need your utility bill with residency showing where you stay. It's a must."

IMPORTANT: When you are interviewed, please bring proof of all household income—for example: pay stubs and award letters for government benefits (such as Social Security). We may also need statements of all household savings-checking accounts, dependent care costs and proof of Tribal membership.

Having these items with you could speed up your application.

Name: _____

P.O. Box

City

State

Zip

Mailing Address: _____

California

Telephone Number Where You Can Be Reached: _____

Residence address—

give directions to your home: _____

YOUR RACIAL-ETHNIC HERITAGE

Although you are not required to provide this information, your cooperation will help determine compliance with Federal Civil Rights law. In no instance will this information be used in considering your application. If you decline to provide this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964.

Black-not of
Hispanic Origin

Hispanic

Asian or Pacific
Islander

American Indian or
Alaskan Native

White-not of
Hispanic Origin

Has anyone living in home received food stamps this month or the previous month or have a case pending?

If **YES**, where? _____ ☐ Yes ☐ No

I Checked Food Stamps Print-Out _____

Fill in all blanks for each household member, including yourself, people who live and eat with you (except roomers and boarders) should also be listed as household members.

I called Welfare on _____ and spoke to _____

We would like you to include the Social Security number of each member of your household who has one, although you are not required to do so. This will help us to identify your household correctly. These Social Security numbers may also be used in program reviews or audits to make sure your household is eligible for food distribution. We are authorized to ask for this information under the Tax Reform Act of 1976.

Checked Residency On Or Near Reservation _____
(If Near, **Must** Verify Tribal Membership)

NAME(S) OF HOUSEHOLD MEMBERS

DATE
OF
BIRTH

SOCIAL SECURITY # AGE

	NAME(S) OF HOUSEHOLD MEMBERS	DATE OF BIRTH	SOCIAL SECURITY #	AGE
1.		/ /		
2.		/ /		
3.		/ /		
4.		/ /		
5.		/ /		
6.		/ /		
7.		/ /		
8.		/ /		
9.		/ /		

Housecall _____

Checked Tribal Membership # _____

RESOURCES (For Example: Cash on Hand, Money in a Savings or Checking Account, Stocks, Bonds, or other Negotiables.) List all Resources of your Household.

RESOURCES (Do not enter the value of excluded resources.)

Cash on Hand \$ _____

Savings Account \$ _____

Checking Account \$ _____

Stocks, Bonds, etc. \$ _____

Other \$ _____

TOTAL HOUSEHOLD RESOURCES
\$ _____

CIRCLE MAXIMUM RESOURCE LIMIT:

\$1,750 \$3,000

COMMENTS ON YOUR HOUSEHOLD OR RESOURCES:

PLEASE FILL IN LEFT HAND COLUMN ONLY

FOR OFFICE USE ONLY

EARNED INCOME

Self-Employed Is anyone in your household self-employed?
 _____ YES _____ NO (Check One)

If yes, please bring in last year's Federal W-2 Tax Forms for all self-employed members of your household, or, if no such tax forms were filed last year, bring proof of all self-employment income and cost expenses.

Wages and Salaries Is anyone in your household employed?

Fill in all blanks for each member with a full or part-time job. If a member has more than one job, list each job separately. Include members who receive income from CETA or WIN. DO NOT include self-employed household members.

Name of Employee	Name of Employer	Gross Check Amt.	How Often Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EARNED INCOME

1. Total gross self-employment income \$ _____
2. Total monthly business costs \$ _____
3. Subtract line 2 from line 1 \$ _____
4. Total monthly gross income from wages and salaries \$ _____
5. Add line 3 to line 4 \$ _____
6. Multiply line 5 by 20% and enter result \$ _____
7. Subtract line 6 from line 5 \$ _____

EDUCATIONAL GRANTS, SCHOLARSHIPS OR LOANS

Please provide copy(s) of financial aid award(s) showing itemized costs.

Source	Amount of Check	How Often Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION

8. Enter monthly income from educational grants, etc., as calculated \$ _____
9. Enter monthly tuition and mandatory fees \$ _____
10. Subtract line 9 from line 8 \$ _____
11. Add line 7 and line 10 together \$ _____

UNEARNED INCOME

Income Source	Who Receives Income	Check Amount	How Often
AFDC (Aid to Families with Dependent Children) Foster Care	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
Social Security	1. _____	_____	_____
	2. _____	_____	_____
SSI (Supplemental Security Income)	1. _____	_____	_____
	2. _____	_____	_____
GA (General Assistance)	1. _____	_____	_____
	2. _____	_____	_____
VA (Veteran's Benefits)	1. _____	_____	_____
	2. _____	_____	_____
Pensions or Retirement Income	1. _____	_____	_____
	2. _____	_____	_____
Unemployment or Workmans Compensation Or Disability Insurance	1. _____	_____	_____
	2. _____	_____	_____

UNEARNED INCOME

12. Total of all unearned
Income \$ _____13. Add line 11 to line
12 \$ _____14. Enter Dependent
Care Costs (Don't
exceed limit)
\$ _____15. Subtract line 14
from line 13
\$ _____16. Net Monthly Income
\$ _____

Child Support or
Alimony

1. _____
2. _____

Money from
Friends or
Relatives

1. _____

Other (Specify)

1. _____

Distribution Payments
from Gambling/
Bingo Profits

1. _____

Dependent Care:

Does anyone in your household pay for someone to babysit or care for a child or disabled adult, so that a member can get work or training or look for a job?

YES NO

If yes, how much do you pay? \$_____ How often: _____

who provides this care? _____ name/address _____ telephone number _____

17. Household size _____

18. Food Distribution
Income Limit For
Appropriate House-
hold Size _____

You have the right to be served without regard to race, color, national origin, religion, political affiliation, sex, handicap, or age and to file a complaint should you feel you have been discriminated against.

To discuss any action regarding your case with the food distribution anytime you are dissatisfied.

To file a complaint or request a fair hearing at any time, write to the Hoopa Valley Council, P.O. Box 1348, Hoopa, CA, Attention: Tribal Manager, or call 625-4211 and ask for the Tribal Manager.

PENALTY WARNING:

If your household receives food distribution, you must follow the rules listed below:

- DO NOT trade or sell food distribution commodities.
- DO NOT use someone else's food distribution commodities for your household.
- DO NOT give false information, or hide information, to get or continue to get food distribution.

I understand the questions on this application. My answers are correct and complete to the best of my knowledge.

I understand that I may have to provide documents to prove what I've said. I agree to do this. If documents are not available, I agree to give the name of a person or organization the office may contact to obtain the necessary proof.

AUTHORIZED REPRESENTATIVE

You can authorize someone outside your household to get your food distribution commodities for you. If you would like to authorize someone, write the person's name below:

Name: _____ Phone: _____

Address: _____

Signature: _____

Today's Date: _____

X

Witness: _____

(If you signed with an X)

You or your representative may request a fair hearing either orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose.

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

**FOR OFFICE USE ONLY
CASE DISPOSITION**

Denied:

Reason: _____

Date: _____

EW: _____

Pending:

Reason: _____

Date: _____

EW: _____

Approved:

Cert. Period: _____

Date: _____

EW: _____

Expedited Service: YES NO

HH Categorically Eligible: YES NO

CPV: YES NO

Received by: _____ Date: _____

AUTHORIZATION FOR ELIGIBILITY INVESTIGATION

I, _____, residing at _____
(name) (address)
_____, hereby authorize:
(city, state, zip code)

The Hoopa Food Distribution Program reviewers to verify my income, checking accounts, savings accounts, insurance, saving certificates, stocks & bonds, disability or retirement benefits, social security, supplemental security income, veterans administration, unemployment benefits, account from IIM office, public assistance grants, AFDC, medical history, tribal affiliation, and any other facts relevant to my eligibility for participation in the Food Distribution Program.

I also authorize any person, partnership, corporation, association, or governmental agency possessing information on such matters to release such information to the reviewers.

I understand this information will be kept confidential.

Applicant signature social security number _____

Spouse signature social security number _____

Please search your records and verify the following information:

The information will be used to determine the initial eligibility or continuing eligibility of the above named individual to receive a program benefit, for statistical purposes to improve program effectiveness; or for enforcement purposes to determine if FNS regulations have been violated and enforcement proceedings are warranted.

Please return all information to:

Hoopa Food Distribution Program
P.O. Box 498
Hoopa, CA 95546
(530)625-4646

Eligibility worker signature

Date